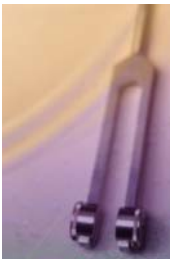
Benefit Comparison Chart & Bi-weekly Insurance Rates



For The Benefit Year

October 2007—September 2008

State of Michigan
Civil Service Commission
Employee Benefits Division

Disclaimer

This is intended as an easy-to-read summary. It is not a contract. Additional limitations and exclusions may apply to covered services. Payment amounts are based on the Blue Cross Blue Shield of Michigan approved amount, less any applicable deductible and /or co-pay amounts required by the State Health Plan PPO. This coverage is provided pursuant to a contract entered into in the State of Michigan and shall be construed under the jurisdiction and according to the laws of the State of Michigan. MSPTA members should reference the Benefit Comparison Chart for Members of the State Police Enlisted Unit.

Preventive Services

$1,500 per year per person (State Health Plan PPO only)

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Health maintenance exam	Covered 100% 1 per year	Not Covered	Covered 100% after $10 office visit co-payment
Annual gynecological exam	Covered 100% 1 per calendar year	Not Covered	
Pap smear screening – laboratory services only [1]	Covered 100% 1 per year	Not Covered	
Well-baby and child care	Covered 100%	Not Covered	
Immunizations [2], annual flu shot & Hepatitis C screening for those at risk	Covered 100%	Not Covered	
Fecal occult blood screening [1]	Covered 100%	Not Covered	
Flexible sigmoidoscopy [1]	Covered 100%	Not Covered	
Colonoscopy [1 & 2]	Covered 100%	Not Covered	
Prostate specific antigen screening [1]	Covered 100% one per year	Not Covered	

[1] American Cancer Society guidelines apply

[2] Childhood immunizations and colonoscopy exams are excluded from the maximum limit

Mammography[1]

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Annual standard film mammography screening (covers digital mammography up to the standard film rate)	Covered 100% Not subject to preventative maximum	Covered 90% after deductible Not subject to preventative maximum	Covered 100%

[1] American Cancer Society guidelines apply

Physician Office Services

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Office visits, consultations and urgent care visits	Covered $10 co-pay, deductible not applicable	Covered 90% after deductible	$10 co-pay
Outpatient and home visits	Covered 100% after deductible	Covered 90% after deductible	

Emergency Medical Care[2]

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Hospital emergency room for medical emergency or accidental injury	Covered 100%		$50 co-pay if not admitted
Ambulance services – medically necessary	Covered 100% after deductible		Covered 100%

[2] Emergency room and physician charges are covered 100% under the Catastrophic Health Plan. Ambulance is covered $25 maximum.

Diagnostic Services

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Laboratory and pathology tests	Covered 100% after deductible	Covered 90% after deductible	Covered 100%
Diagnostic tests and x-rays			
Radiation therapy			

Maternity Services

Includes care by a certified nurse midwife (State Health Plan PPO only)

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Prenatal and postnatal care	Covered 100% after deductible	Covered 90% after deductible	Office Visit $10 co-pay
Delivery and nursery care [3]			Covered 100%

[3] Delivery and well-baby care in the hospital are covered 100% under the Catastrophic Health Plan.

Hospital Care

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Semi-private room, inpatient physician care, general nursing care, hospital services and supplies	Covered 100% after deductible, unlimited days	Covered 90% after deductible, unlimited days	Covered 100% Unlimited days
Inpatient consultations	Covered 100% after deductible	Covered 90% after deductible	Covered 100%
Chemotherapy			

Alternatives to Hospital Care

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Skilled nursing care up to 120 days per confinement (730 days for UAW)	Covered 100% after deductible		Covered 100% up to 730 days
Hospice care	Covered 100% Limited to the lifetime dollar maximum that is adjusted annually by the State		Covered 100%
Home health care	Covered 100% after deductible, unlimited visits		Check with your HMO

Surgical Services

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Surgery—includes related surgical services.[4]	Covered 100% after deductible	Covered 90% after deductible	Covered 100%
Voluntary sterilization			Check with your HMO

[4] Inpatient hospital services are 100% covered after deductible under the Catastrophic Health Plan.

Human Organ Transplants

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Liver, heart, lung, pancreas, and other specified organ transplants	Covered 100% In designated facilities only. Up to $1 million lifetime maximum for each organ transplant		Covered 100% in designated facilities

Organ and Tissue Transplants

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Bone marrow—specific criteria apply	Covered 100% after deductible in designated facilities	Covered 90% after deductible	Covered 100% in designated facilities
Kidney, cornea, and skin			Covered 100% subject to medical criteria

Other Services

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Allergy testing and injections	Covered 100% after deductible	Covered 90% after deductible	Office visits: $10 co-pay Injections: Covered 100%
Acupuncture	Covered 90% after deductible if performed by or under the supervision of a M.D. or D.O.		Check with your HMO
Rabies treatment after initial emergency room visit	Covered 100% after deductible	Covered 90% after deductible	Office visits: $10 co-pay Injections: Covered 100%
Chiropractic/spinal manipulation [5]	Covered 100% after $10 co-pay Up to 24 visits per calendar year	Covered 90% after deductible Up to 24 visits per calendar year	Check with your HMO
Durable medical equipment	Covered 100%	Covered 80% after deductible	Covered
Prosthetic and orthotic appliances			

[5] MSEA employees are covered up to 36 visits per calendar year under the State Health Plan PPO. MCO employees are covered 90% after deductible for both in and out-of-network services.

Other Services continued...

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Private duty nursing	Covered 90% after deductible		Covered
Wig, wig stand, adhesives	Upon meeting medical conditions, eligible for a lifetime maximum reimbursement of $300. (Additional wigs covered for children due to growth).		Check with your HMO
Laser eye surgery (MSEA employees only)	$755 lifetime limit		Check with your HMO
Hearing care	Covered 100% after medical clearance exam by physician	Not covered [6]	Check with your HMO

[6] Not all areas have a network of hearing providers. If there is no network in your area, your provider may participate on a per claim basis. If your provider does not wish to participate, you may pay for services and submit a claim. You will be reimbursed up to the allowed amount for covered services.

Mental Health/Substance Abuse

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Mental Health Benefits - **Inpatient**	Covered 100% up to 365 days per year [7]	Covered 50% up to 365 days per year	Check with your HMO
Mental Health Benefits - **Outpatient**	As necessary 90% of network rates 10% co-pay	As necessary 50% of network rates	
Alcohol & Chemical Dependency Benefits - **Inpatient**	Covered 100% [8] Halfway House 100%	Covered 50% [8] Halfway House 50%	
Alcohol & Chemical Dependency Benefits - **Outpatient**	$3,500 per calendar year 90% of network rates 10% co-pay [9]	$3,500 per calendar year 50% of network rates	

[7] Inpatient days may be utilized for partial day hospitalization (PHP) at 2:1 ratio. One inpatient day equals two PHP days.

[8] Up to two 28-day admissions per year. There must be at least 60 days between admissions. Inpatient days may be utilized for intensive outpatient treatment (IOP) at 2:1 ratio. One inpatient day equals two IOP days.

[9] $3,500 per calendar year limitation pertains to services for chemical dependency only.

Prescription Drugs

Prescription medications for the State Health Plan PPO are covered under the Participating Pharmacy ID Card Plan administered by Express Scripts. The co-pays for prescription drugs (both retail and mail order) are based on the employee's bargaining unit.

Prescriptions filled at a participating pharmacy may only be approved for up to a 34-day supply. Employees can still receive a 90-day supply by mail order.

Employee Group	Generic	Brand Name Preferred	Brand Name Non-Preferred
Non-Exclusively Represented Employees (NERE) (including Judicial employees)	$7	$15	$30
Institutional Unit represented by AFSCME			
HSS, S & E, and Technical Units represented by SEIU Local 517M			
Labor and Trades, Safety and Regulatory Units represented by MSEA			
Security Unit represented by MCO			
Human Services and Administrative Support Units represented by UAW [10]	$7	$15	N/A

[10] The prescription drug program will promote the use of generic drugs. Prescription medications on the maintenance drug list (MDL) used on a long term basis will be available only through mail order home delivery per the terms of the contract.

To check the co-pay for drugs you may be taking, visit Express Scripts website at http://www.express-scripts.com or contact Express Scripts at (800) 505-2324. The Preferred/Non-preferred list of drugs is updated periodically as new drugs are added.

For information about HMO prescription drug coverage, check with the HMO provider.

Outpatient Physical, Speech, and Occupational Therapy

Combined maximum of 90 visits per calendar year.

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Outpatient physical, speech and occupational therapy – facility and clinic services	Covered 100% after deductible		Office visit: $10 co-pay
Outpatient physical therapy – physician's office	Covered 100% after deductible	Covered 90% after deductible	Office visit: $10 co-pay

Deductible, Co-Pays, and Out-of-Pocket Dollar Maximums

	State Health Plan PPO		HMO Benefits
	In-network	Out-of-network	
Deductible	$200 per member $400 per family	$500 per member $1,000 per family	None
Fixed dollar co-pays	$10 for office visits, office consultations, urgent care visits, osteopathic manipulations, chiropractic manipulations (for all employees except MCO) and medical hearing exams	Not applicable, but deductible and co-pay apply	$10 for office visits $50 for emergency room visits, if not admitted
Percent co-pays	10% for private duty nursing, chiropractic manipulation (for MCO members) and acupuncture	10% for most services	None
Annual out-of-pocket dollar maximums [11]	$1,000 per member $2,000 per family	$2,000 per member $4,000 per family	None

[11] The out-of-pocket limit does not apply to deductibles, fixed dollar co-payments, or private duty nursing co-payments.

Dental Care Options

Covered Services *(does not apply to members represented by MSPTA T01)*	**State Dental Plan**	**DMO Plan**	**Preventive Dental Plan**
Diagnostic Exams and Consultations (2 per year)	100%	100%	100%
Preventive Services			
▪Teeth cleaning (3 per year)	100%	100%	100%
▪Topical fluoride (under age 19)	100%	100%	100%
▪Space maintainers (under age 14)	100%	100%	100%
▪Sealants (under age 14)	50%	100%	Not Covered
Radiographs	90%	100%	Not Covered
Brush Biopsy	100%	N/A	100%
Oral Surgery	90%	100%	100%
Extractions	90%	100%	Not Covered
Minor Restoratives	90%	100%	Not Covered
Major Restoratives	90%	100%	Not Covered
Endodontics	90%	100%	Not Covered
Periodontics	90%	100%	Not Covered
Prosthodontics	50%	100%	Not Covered
Prosthodontics Repair	50%	100%	Not Covered
Orthodontics			
Up to age 19	60%	100%	Not Covered
19 and over	60%	$1,250 co-pay	Not Covered
Benefit Maximums			
Annual (Oct. – Sept.)	$1,500	None	None
Lifetime Orthodontics	$1,500	None	N/A

This benefit summary is a brief explanation only. All plan provisions (including exclusions and limitations) are subject to the specific terms of the State and Preventive Dental Plans and the Group Dental Services Agreement (Midwestern Dental Plans, Inc.).

Group Insurance Premium Rates

Effective October 7, 2007

		BIWEEKLY RATE		
	Option*	Employee	State	Total
State Health Plan - BCBS PPO	1	$ 11.90	$ 226.19	$ 238.09
	2	$ 23.81	$ 452.38	$ 476.19
	3	$ 20.95	$ 398.09	$ 419.04
	4	$ 32.86	$ 624.28	$ 657.14
Employee or Spouse w/ Medicare (State pays 100%)	5	$ 0.00	$ 226.19	$ 226.19
	6	$ 0.00	$ 452.38	$ 452.38
	7	$ 0.00	$ 398.09	$ 398.09
	8	$ 0.00	$ 624.28	$ 624.28
Catastrophic Health Plan (State pays 100%)	1	$ 0.00	$ 15.81	$ 15.81
	2	$ 0.00	$ 31.62	$ 31.62
	3	$ 0.00	$ 31.62	$ 31.62
	4	$ 0.00	$ 31.62	$ 31.62
Blue Care Network Mid-Michigan	1	$ 0.00	$ 218.29	$ 218.29
	2	$ 0.00	$ 436.58	$ 436.58
	3	$ 0.00	$ 384.19	$ 384.19
	4	$ 0.00	$ 602.48	$ 602.48
Blue Care Network East Michigan	1	$ 0.00	$ 205.40	$ 205.40
	2	$ 0.00	$ 410.81	$ 410.81
	3	$ 0.00	$ 361.51	$ 361.51
	4	$ 0.00	$ 566.91	$ 566.91
Blue Care Network Great Lakes West	1	$ 0.00	$ 207.77	$ 207.77
	2	$ 0.00	$ 415.54	$ 415.54
	3	$ 0.00	$ 365.68	$ 365.68
	4	$ 0.00	$ 573.45	$ 573.45
Blue Care Network SE Michigan	1	$ 0.00	$ 203.38	$ 203.38
	2	$ 0.00	$ 406.75	$ 406.75
	3	$ 0.00	$ 357.94	$ 357.94
	4	$ 0.00	$ 561.32	$ 561.32
Grand Valley Health Plan	1	$ 0.00	$ 204.78	$ 204.78
	2	$ 0.00	$ 409.55	$ 409.55
	3	$ 0.00	$ 360.41	$ 360.41
	4	$ 0.00	$ 565.18	$ 565.18
Health Alliance Plan	1	$ 0.00	$ 197.53	$ 197.53
	2	$ 0.00	$ 396.77	$ 396.77
	3	$ 0.00	$ 348.96	$ 348.96
	4	$ 0.00	$ 548.19	$ 548.19
HealthPlus of Michigan	1	$ 0.00	$ 209.54	$ 209.54
	2	$ 0.00	$ 419.08	$ 419.08
	3	$ 0.00	$ 368.79	$ 368.79
	4	$ 0.00	$ 578.33	$ 578.33

* Health, dental and vision option codes are: 1 = Employee only coverage, 2 = Employee & Spouse, 3 = Employee & Child(ren), 4 = Full Family, 5 = Employee with Medicare, 6 = Employee & Spouse with Medicare, 7 = Employee & Child(ren) with Medicare, 8 = Full Family with Medicare

Group Insurance Premium Rates

Effective October 7, 2007

		BIWEEKLY RATE		
	Option*	Employee	State	Total
McLaren Health Plan	1	$ 0.00	$ 188.89	$ 188.89
	2	$ 0.00	$ 377.79	$ 377.79
	3	$ 0.00	$ 332.46	$ 332.46
	4	$ 0.00	$ 521.35	$ 521.35
Physicians Health Plan - Lansing	1	$ 0.00	$ 225.35	$ 225.35
	2	$ 0.00	$ 448.92	$ 448.92
	3	$ 0.00	$ 394.66	$ 394.66
	4	$ 0.00	$ 619.20	$ 619.20
Priority Health Plan - West	1	$ 0.00	$ 208.05	$ 208.05
	2	$ 0.00	$ 416.10	$ 416.10
	3	$ 0.00	$ 366.16	$ 366.16
	4	$ 0.00	$ 574.24	$ 574.24
Priority Health Plan - East	1	$ 0.00	$ 225.99	$ 225.99
	2	$ 0.00	$ 451.98	$ 451.98
	3	$ 0.00	$ 397.74	$ 397.74
	4	$ 0.00	$ 623.74	$ 623.74
Priority Health Plan - South	1	$ 0.00	$ 225.99	$ 225.99
	2	$ 0.00	$ 451.98	$ 451.98
	3	$ 0.00	$ 397.74	$ 397.74
	4	$ 0.00	$ 623.74	$ 623.74
Total Health Care	1	$ 0.00	$ 138.56	$ 138.56
	2	$ 0.00	$ 318.70	$ 318.70
	3	$ 0.00	$ 263.27	$ 263.27
	4	$ 0.00	$ 374.12	$ 374.12

* Health, dental and vision option codes are: 1 = Employee only coverage, 2 = Employee & Spouse, 3 = Employee & Child(ren), 4 = Full Family

Vision Premium Rates

Effective October 7, 2007

		BIWEEKLY RATE		
	Option*	Employee	State	Total
State Vision Plan (State pays 100%)	1	$ 0.00	$ 2.80	$ 2.80
	2	$ 0.00	$ 4.93	$ 4.93
	3	$ 0.00	$ 6.02	$ 6.02
	4	$ 0.00	$ 8.16	$ 8.16

* Health, dental and vision option codes are: 1 = Employee only coverage, 2 = Employee & Spouse, 3 = Employee & Child(ren), 4 = Full Family

Dental Premium Rates

Effective October 7, 2007

		BIWEEKLY RATE		
	Option*	**Employee**	**State**	**Total**
State Dental Plan	1	$ 1.08	$ 20.48	$ 21.56
	2	$ 1.97	$ 37.38	$ 39.35
	3	$ 2.40	$ 45.52	$ 47.92
	4	$ 3.28	$ 62.36	$ 65.64
Preventive Dental Plan (State pays 100%)	1	$ 0.00	$ 2.99	$ 2.99
	2	$ 0.00	$ 5.21	$ 5.21
	3	$ 0.00	$ 5.21	$ 5.21
	4	$ 0.00	$ 7.42	$ 7.42
Midwest Dental (DMO) (State pays 100%)	1	$ 0.00	$ 15.99	$ 15.99
	2	$ 0.00	$ 15.99	$ 15.99
	3	$ 0.00	$ 15.99	$ 15.99
	4	$ 0.00	$ 15.99	$ 15.99

* Health, dental and vision option codes are: 1 = Employee only coverage, 2 = Employee & Spouse, 3 = Employee & Child(ren), 4 = Full Family

Dependent Life Premium Rates

Effective October 7, 2007

		BIWEEKLY RATE		
	Option	**Employee**	**State**	**Total**
Spouse $1,500 and/or Child(ren) $1,000	1	$ .20	$ -	$ .20
Spouse $5,000 and/or Child(ren) $2,500	2	$ .60	$ -	$ .60
Spouse $10,000 and/ or Child(ren) $5,000	3	$ 1.20	$ -	$ 1.20
Spouse $25,000 and/ or Child(ren) $10,000	4	$ 4.00	$ -	$ 4.00
Child(ren) only $10,000	5	$ .75	$ -	$ .75

Long Term Disability (LTD) Premium Rates

Effective October 7, 2007

Plan Name/Code	Status	Employee	State
YIA0: Less than 184 hours sick leave	Plan I	$ 2.08 $ 2.13*	$ .94 $ .94
YIA1: 184-527 hours sick leave	Plan IIA	$ .53 $ .58*	$ .94 $ .94
YIA2: 528 hours or more sick leave	Plan IIB	$ - $ - *	$ .94 $ .94
YIA3: Reach Plan II (YIA1) but now less than 184 hours sick leave	Plan IIC	$ 1.74 $ 1.79*	$ .94 $ .94

* Premium rates for employees represented by UAW only.

Calculation of Employee Contribution:

Bi-weekly contribution = Hourly Rate times 2088, divided by 26, divided by 100, times Employee Rate per Plan (I, IIA, IIB, or IIC)

If you have questions about LTD, please contact Employee Health Management at (517) 241-9090.

Notes

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Employee Benefits Division Website
www.michigan.gov/mdcs

MI HR Self-Service & MI HR Information
www.michigan.gov/selfserv